DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Children and Family Services
CFS-2139 (Rev. 10/2002)

RESIDENTIAL CARE CENTER RESIDENT RECORD CHECKLIST

Use of form: This form is to be used by Licensing Specialists to review a Residential Care Center's (RCC) resident record requirements under HFS 52. This form may also be used by Residential Care Centers to review their compliance with resident records requirements under HFS 52.

Instructions: Review Residential Care Center's resident records and place a check or date in the compliance box if the information is found in the resident's record. Enter "N/A" if item does not apply.

Name - Facility	Address - Facility (Street, City, Zip Code)
Name - Licensing Specialist	Date - Checklist Completed

Rule	Name	Name	Name	Name
1. Records maintained at location where resident resides. s. 52.49(2)(a)				
2. Pre-admission screening report including: s. 52.21(2)				
Pre-admission review.				
Primary presenting problems.				
Reasons for or against admission.				
Signature and date report signed.				
3. Basic information including:				
Name, gender, race, religion, birth date and birthplace of the resident. s. 52.49(2)(b)4.a.				
Name, address, and telephone number of resident's responsible person at the time of admission. s. 52.49(2)(b)4.b.				
Date resident was admitted and referral source. s. 52.49(2)(b)4.c.				
Documentation of court status, custody, and / or guardianship arrangements including copies of any court order, placement agreement, or other authorization relating to placement. s. 52.49(2)(b)4.d.				
History of the resident and family. s. 52.49(2)(b)1.a.				
Recent photo of the resident. s. 52.49(2)(b)1.k.				
Prior approval from the department before admitting any child age six or under. s. 52.21(3)(b)				
Records of any vocational training or employment experiences. s. 52.49(2)(b)4.f.				

Rule	Name	Name	Name	Name
4. Progress notes and reviews:				
Assessment of progress. s. 52.22(3)(a)1.				
Significant events. s. 52.22(3)(a)2.				
Reviews conducted every three months or more often if necessary. s. 52.22(3)(b)1.				
Dates of reviews and names of those participating. s. 52.22(3)(c)				
5. Any report of abuse or neglect of the resident. s. 52.49(2)(b)1.I.				
6. Written needs assessment and treatment plan which includes: (Completed within 30 days after admission.)				
Strengths and weaknesses in various areas. s. 52.22(2)(a)1-8				
Treatment goals. s. 52.22(2)(b)1.				
Permanency planning goals. s. 52.22(2)(b)1.				
Behavioral or functional objectives. s. 52.22(2)(b)2.				
Conditions for discharge. s. 52.22(2)(b)3.				
Any specialized services. s. 52.22(2)(b)4.				
Resident and family services. s. 52.22(2)(b)5.				
Date and signature. s. 52.22(2)(c)1.				
7. External service providers:				
Required reports from external service providers on resident's progress. s. 52.12(8)(a)3.				
Notification to placing person or agency if support services from external service providers are needed, including type of service, needs of resident and amount of time needed for services. s. 52.12(8)(b)				
8. Service contracts: (Not required to be on-site.)				
Copy of contract or other agreement with the resident's responsible person or placing agency to provide services to the resident. s. 52.21(4)				
9. Aftercare plan which includes:				
Names of people and agencies that developed the plan. s. 52.23(1)(b)1.				
Recommendations for services and names of providers. s. 52.23(1)(b)2.				
Name, address, telephone number and relationship to the resident of person or agency who will receive the resident. s. 52.23(1)(b)3.				

Rule	Name	Name	Name	Name
9. Continued.				
Documentation that the resident (if able to understand) and the resident's responsible person(s) and placing agency have received a copy of the aftercare plan. s. 52.23(1)(c)				
Completion of the Aftercare plan 30 days prior to planned discharge. s. 52.23(1)(b)				
10. Discharge Summary:				
Sent to placing agency within 30 days after discharge. s. 52.23(3)				
Copy in resident's file within 30 days after discharge. s. 52.23(3)				
Date and reason for discharge. s. 52.23(3)(a)				
Summary of services provided during care. s. 52.23(3)(b)				
Assessment of goals achieved. s. 52.23(3)(c)				
Description of remaining needs. s. 52.23(3)(d)				
11. Educational record which includes: s. 52.43(5)				
Results of educational assessments.				
Educational goals.				
Progress reports.				
12. Restitution plan if applicable. s. 52.41(8)(b)1.				
13. Interstate Compact Office:				
Written approval from ICPC office prior to accepting an out-of-state resident for placement including resident's social, medical and educational history. s. 52.21(3)(a)				
Notify ICPC office at end of each month of all out-of-state discharges for the month. s. 52.23(4)				
Who received resident at discharge. s. 52.23(4)				
Destination of the resident. s. 52.23(4)				
14. Written consents including:				
Signed consents required under 94.03 - Resident Rights.				
Consent for non-emergency use of psychotropic medication signed by the resident (if over 14 years of age) and the resident's responsible person. s. 52.46(5)(c)2.				
Consent for use of locked unit signed by the resident's responsible person or order from a court or other lawful authority. s. 52.42(7)(a)3.d.				

Rule	Name	Name	Name	Name
14. Continued.				
Consent for routine medical and dental services. s. 52.21(5)(a)1.				
Consent for staff to administer medication. s. 52.21(5)(a)2.				
Consent for facility to obtain other medical information on the resident. s. 52.21(5)(a)3.				
Consent for emergency medical procedures. s. 52.21(5)(a)4.				
Consent from parent or guardian for church attendance and religious instruction when agency practice varies from that of the resident or the resident's family. (Not required for respite care residents.) s. 52.41(5)(b)				
15. Documentation of denial of resident's rights. s. 52.49(2)(b)1.i.				
16. Copies of resident's grievances and responses to them. s. 52.49(2)(b)1.i.				
17. Psychotropic medication:				
If psychotropic medication is given, a written report from the prescribing physician is required within 45 days after the first dose of the medication and at least every 60 days thereafter. s. 52.46(5)(c)3.				
Documentation of any emergency administration of psychotropic medication to a resident. s. 52.46(5)(d)4.				
Documentation of physician's reasons for ordering emergency administration of psychotropic medication. s. 52.46(5)(d)5.				
Documentation of revocation of consent to use non-emergency psychotropic medications. s. 52.46(5)(e)2.b.				
Documentation of reasons why a resident refused to take prescribed psychotropic medication along with written statements from two staff persons who witnessed the refusal. s. 52.46(5)(e)3.a.				
18. Copies of physical crisis intervention incident reports including:				
Resident's name, age, and gender. s. 52.42(6)(a)1.				
Description of the incident including date, time, location, duration, and methods used to deal with the behavior. s. 52.42(6)(a)2. and 3.				
Results of methods used to address behavior. s. 52.42(6)(a)4.				
Names of staff members involved. s. 52.42(6)(a)5.				
Injuries to resident or staff; how injuries happened; and medical care provided. s. 52.42(6)(a)6.				
Maintaining a log of incident reports in each building housing residents which includes the first two items above. s. 52.42(6)(b)				

Rule	Name	Name	Name	Name
19. Health records including:				
Physical examination done within one year prior to, or within two days after admission. s. 52.21(8)(a)1. and 2.				
Dental examination done within one year prior to, or within 90 days after admission. s. 52.21(8)(a)1. and 2.				
Follow-up dental exams as required by HealthCheck rules or as provided by insurance coverage. s. 52.45(1)(b)				
Necessary and remedial corrective measures for physical / dental problems. s. 52.45(1)(c)				
Dates and results of physical, mental health, and dental examinations. s. 52.45(4)b.				
Physical examination shall document areas found on the HealthCheck age appropriate form. s. 52.45(1)(a)				
Documentation that resident has been observed for signs of illness at admission and results of that observation. s. 52.21(8)(b)				
Resident's health history and, if applicable, medication history both prior to admission and during the resident's stay. s. 52.45(4)(c)				
Information on immunizations, lab tests, routine medical and dental treatment and emergency care while the resident is at the center. s. 52.45(4)(d)1.-5.				
Information about health allergies or health related restrictions. s. 52.46(2)(a)2.				
Nutritional care plan, approved by a registered dietitian if resident has special dietary needs. s. 52.44(2)(c)				
Written medication administration record for the resident.				
Over-the-counter medication. The record must include the resident's name; type of medication; reason for use; time and day of administration; and name of authorizing staff person. s. 52.46(4)(a)1.				
Prescription medication. The record must include the resident's name; name of medication; date prescribed; name and telephone number of physician; reason for taking the medication; dosage; time; date; method of administration; name of staff person who gave the medication; any adverse effects; and any errors or corrective action taken. s. 52.46(4)(a)2.a.-k.				